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November 18, 2009

Senator John L. Valentine, Senate Chair, Business and Labor Interim Committee Representative James A. Dunnigan, House Chair, Business and Labor Interim Committee

Subject:: Health System Reform Task Force Preliminary Report

Dear Chairs:

Although the work of the Health System Reform Task Force is not yet completed, we are providing a preliminary report for consideration at your November interim meeting.

Accompanying this report is a draft bill recommended by the Task Force ("Health Reform - Administrative Simplification") and two other draft bills the Task Force will review at its November interim meeting ("Amendments to Health Insurance Coverage in State Contracts" and "Health Reform - Uniform Electronic Standards - Insurance Information").

The Task Force is authorized to work through December 30. Although we have no additional meetings scheduled, we may meet again to further consider issues outlined below and related draft legislation.

ORGANIZATION OF TASK FORCE Work During 2008, the Task Force relied heavily on the expertise and input of five working groups organized around functional areas within the health care system—consumers, employers, insurers, physicians, and hospitals. This year, the Task Force reorganized the workgroup structure to create three working groups and several technical advisory groups (TAGs) working under their direction. Each workgroup addressed a specific set of tasks and reported to the Task Force. The result of this work is summarized below and, in some cases, incorporated into the accompanying draft legislation. Detailed information about the issues studied by the Task Force and its working groups is available at http://www.le.utah.gov/asp/interim/Commit.asp?Year=2009&Com=TSKHSR (see especially http://www.le.utah.gov/interim/2009/pdf/00001033.PDF).

Focus During the 2007, 2008, and 2009 General Sessions, the Legislature enacted legislation designed to lay a foundation for significant future health care reform. The Task Force's work during the 2009 interim focused largely on ensuring that work on this foundation is proceeding as planned. Major topics considered by the Task Force and its subgroups are outlined below.

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Insurance Market Reform On August 19, the state opened the second of only two health insurance purchasing exchanges in the country. The Exchange is a virtual marketplace that emphasizes various elements of consumerism—availability of price and quality information about plans, availability of insurer performance information, availability of a large number of plan choices from which individual employees—rather than employers—may choose, and capacity to aggregate financial resources from multiple sources to make a purchase.

Interest in the Exchange has been strong. Enrollment was closed after only two weeks. Enrollment will be limited for a period but then opened to all small employer groups later next year and to large employer groups in 2012.

The Task Force has closely monitored the development of various aspects of the Exchange, including the availability and cost of plans, the availability of consumer information, and the development of a risk-adjusting mechanism by the Utah Defined Contribution Risk Adjuster Board. Our Oversight and Implementation Workgroup has considered various statutory amendments relating to the Exchange, including the following:

- allowing for continuous enrollment;
- clarifying price, value, and performance provisions;
- convening a group to study simplification of the uniform health insurance application;
 and
- allowing an insurer in the defined contribution market to offer a product with an actuarial value 15% less than the basic benefit package.

The Task Force is not recommending at this time that any of these amendments, or other changes to the insurance market, be adopted. This, however, may change between now and the 2010 General Session.

Payment and Delivery Reform Pursuant to 2009 legislation, the State has contracted with HealthInsight, a recognized health care quality improvement organization, to work with medical providers, insurers, and others to develop pilot programs that test payment and delivery reform concepts. This includes medical home, bundled payment, and shared savings concepts. HealthInsight expects to enlist medical providers early next year and provide preliminary results sometime during the 2010 interim. The first two projects test payment reform using a chronic care delivery model (for patients with diabetes) and an acute care delivery model (for pregnant patients). The Task Force and our Transparency, Quality, and Infrastructure Workgroup have monitored the development of these projects. We are not recommending legislation at this time to facilitate, expand, or accelerate these projects.

ADOPTION OF HEALTH INFORMATION TECHNOLOGY Pursuant to 2008 legislation, the Utah Health Information Network (UHIN) has developed standards for electronic clinical health information exchange (cHIE) across providers belonging to different health care systems or no system at all. UHIN has begun to pilot data exchange in three locations—Moab, Box Elder County, and

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Cache County. Of the 168 physicians in these areas, 161 have indicated they wish to participate in the pilots. Statewide implementation is expected to begin January 2010. It is expected that use of cHIE will lead to greater use of electronic medical records and, based on results elsewhere, lower prescribing rates and decreased use of emergency departments.

The Task Force is not recommending any legislative action at this time to facilitate or accelerate electronic clinical health information exchange.

ALL-PAYER DATABASE (APD) In response to 2007 legislation, the Department of Health has been developing the capacity to produce risk-adjusted payment data for entire episodes of medical care. APD data will differ from existing data which report what *providers charge*. APD data will instead report what *insurers pay* and will be rolled up across visits and providers to arrive at the cost of treating entire episodes of care (e.g., the cost of treating a coronary obstruction, which may involve multiple providers, procedures, and patient visits).

The all-payer database is expected to enable and accelerate transformational payment and delivery reform. The data will be used to identify insurance plan provisions and provider practice patterns that result in higher quality care and lower costs. Ultimately, the data may be used by consumers in the selection of insurance plans and health care providers.

The Task Force is not recommending any legislation at this time relating to the development and operation of the all-payer database.

Insurance In State Contracts In 2009 the Legislature passed legislation that would require employers contracting with certain government agencies to offer their employees health insurance. Our Oversight and Implementation Workgroup studied this legislation and suggested several changes. Those changes are recommended by the Task Force and are included in accompanying draft legislation, "Amendments to Health Insurance Coverage in State Contracts." They include:

- · clarifying to whom qualified insurance must be offered;
- clarifying what may be offered;
- clarifying how an employer offering a defined contribution arrangement may comply;
- clarifying the application of a waiting period; and
- amending enforcement provisions.

ADMINISTRATIVE SIMPLIFICATION In 2009 the Legislature passed legislation designed to simplify various aspects of health insurance administration. The Task Force's Affordability and Access Workgroup reviewed this legislation and prepared amendments for consideration during the 2010 General Session. The Task Force recommends these amendments, included in two accompanying pieces of draft legislation, "Health Reform - Uniform Electronic Standards - Insurance Information" and "Health Reform - Administrative Simplification." They include:

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- amending provisions related to uniform electronic standards for health insurance claims processing, electronic insurance eligibility information, and electronic information regarding the coordination of benefits;
- establishing a voluntary registry of software vendors who comply with electronic standards:
- providing uniform language for divorce decrees and child support orders related to the coordination of health insurance benefits when a dependent child of a marriage is covered by both parents' health insurance policies;
- establishing a coordination of benefits process for health insurance claims based primarily on national standards;
- providing uniform educational material for the public regarding the coordination of health insurance benefits:
- repealing the coordination of health insurance benefits process that was to take effect July 1, 2010; and
- · making clarifying and technical amendments.

Public Employees Health Program The Task Force's Transparency, Quality, and Infrastructure Workgroup conducted an in-depth review of the extent to which the state's Public Employee's Health Program (PEHP) incorporates and might further incorporate various reform concepts to reduce cost, improve care, incentivize personal responsibility, and create individual and provider accountability. The concepts reviewed included bundled payments, premium differentials based on wellness program participation or outcomes, health savings accounts, and use of lower-cost care providers (health clinics, ambulatory surgery centers, medical tourism providers, and alternative medicine providers).

PEHP will continue to study the desirability of incorporating these concepts in its plans. The Task Force is not recommending any legislative action at this time relating to PEHP.

PROMOTION OF WELLNESS The Task Force's Affordability and Access Workgroup reviewed approaches to improving individual and community wellness but made no recommendations. The Task Force received a report on the development of a community-wide initiative in Midvale to promote healthy behaviors. The Task Force is not recommending any legislative action at this time to address wellness promotion.

TORT REFORM The Task Force's Transparency, Quality, and Infrastructure Workgroup reviewed how Utah medical liability laws compare with the laws of other states and how Utah's approach to medical liability might be modified. The Task Force is not recommending legislation at this time to address medical liability.

Access to Public Programs The Task Force's Affordability and Access Workgroup reviewed options for facilitating enrollment in the Children's Health Insurance Program, Medicaid, and the

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Utah's Premium Partnership for Health Insurance (UPP). These options included methods for identifying individuals eligible for programs and eliminating barriers to enrollment. The Task Force is not recommending legislation at this time to address access to public programs.

For further information, please feel free to contact us or other members of the Task Force.

Sincerely,

Speaker David Clark

House Chair

Health System Reform Task Force

Senator Sheldon L. Killpack

Senate Chair

Health System Reform Task Force

Enclosures:

Health Reform - Administrative Simplification

Amendments to Health Insurance Coverage in State Contracts

Health Reform - Uniform Electronic Standards - Insurance Information

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1	HEALTH REFORM - ADMINISTRATIVE
2	SIMPLIFICATION
3	2010 GENERAL SESSION
4	STATE OF UTAH
5	I ONG PRINT T
6	LONG TITLE
7	General Description:
8	This bill amends provisions related to administrative simplification of the coordination
9	of health insurance benefits as provided in divorce decrees, child support orders, and
10	the Insurance Code.
11	Highlighted Provisions:
12	This bill:
13	 provides uniform language for divorce decrees and child support orders related to
14	the coordination of health insurance benefits when a dependent child of the
15	marriage is covered by both parents' health insurance policies;
16	 establishes a coordination of benefits process for health insurance claims based
17	primarily on national standards;
18	 provides uniform educational material for the public regarding the coordination of
19	health insurance benefits; and
20	repeals the coordination of health insurance benefits process that was to take effect
21	July 1, 2010.
22	Monies Appropriated in this Bill:
23	None
24	Other Special Clauses:
25	None
26	Utah Code Sections Affected:
27	AMENDS:
28	30-3-5, as last amended by Laws of Utah 2005, Chapter 129
29	31A-22-619, as last amended by Laws of Utah 2009, Chapter 11
30	63I-2-231, as last amended by Laws of Utah 2009, Chapter 11
31	624-11-326 as last amended by I awa of Utah 2000 Chanter 142

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78B-12-212, as last amended by Laws of Utah 2009, Chapter 142
ENACTS:
30-3-5.5 , Utah Code Annotated 1953
REPEALS:
31A-22-619.5 (Effective 07/01/10), as enacted by Laws of Utah 2009, Chapter 11
Be it enacted by the Legislature of the state of Utah:
Section 1. Section 30-3-5 is amended to read:
30-3-5. Disposition of property Maintenance and health care of parties and
children Division of debts Court to have continuing jurisdiction Custody and
parent-time Determination of alimony Nonmeritorious petition for modification.
(1) When a decree of divorce is rendered, the court may include in it equitable orders
relating to the children, property, debts or obligations, and parties. The court shall include the
following in every decree of divorce:
(a) an order assigning responsibility for the payment of reasonable and necessary
medical and dental expenses of the dependent children including responsibility for health
insurance out-of-pocket expenses such as co-payments, co-insurance, and deductibles;
(b) (i) if coverage is or becomes available at a reasonable cost, an order requiring the
purchase and maintenance of appropriate health, hospital, and dental care insurance for the
dependent children; and
(ii) a designation of which health, hospital or dental insurance plan is primary and
which health, hospital, or dental insurance plan is secondary in accordance with the provisions
of Section 30-3-5.5 which will take effect if at any time a dependent child is covered by both
parents' health, hospital or dental insurance plans.
(c) pursuant to Section 15-4-6.5:
(i) an order specifying which party is responsible for the payment of joint debts,
obligations, or liabilities of the parties contracted or incurred during marriage;
(ii) an order requiring the parties to notify respective creditors or obligees, regarding
the court's division of debts, obligations, or liabilities and regarding the parties' separate,
current addresses; and
(iii) provisions for the enforcement of these orders; and

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(d) provisions for income withholding in accordance with Title 62A, Chapter 11, Recovery Services.

- (2) The court may include, in an order determining child support, an order assigning financial responsibility for all or a portion of child care expenses incurred on behalf of the dependent children, necessitated by the employment or training of the custodial parent. If the court determines that the circumstances are appropriate and that the dependent children would be adequately cared for, it may include an order allowing the noncustodial parent to provide child care for the dependent children, necessitated by the employment or training of the custodial parent.
- (3) The court has continuing jurisdiction to make subsequent changes or new orders for the custody of the children and their support, maintenance, health, and dental care, and for distribution of the property and obligations for debts as is reasonable and necessary.
- (4) Child support, custody, visitation, and other matters related to children born to the mother and father after entry of the decree of divorce may be added to the decree by modification.
- (5) (a) In determining parent-time rights of parents and visitation rights of grandparents and other members of the immediate family, the court shall consider the best interest of the child.
- (b) Upon a specific finding by the court of the need for peace officer enforcement, the court may include in an order establishing a parent-time or visitation schedule a provision, among other things, authorizing any peace officer to enforce a court-ordered parent-time or visitation schedule entered under this chapter.
- (6) If a petition for modification of child custody or parent-time provisions of a court order is made and denied, the court shall order the petitioner to pay the reasonable attorneys' fees expended by the prevailing party in that action, if the court determines that the petition was without merit and not asserted or defended against in good faith.
- (7) If a petition alleges noncompliance with a parent-time order by a parent, or a visitation order by a grandparent or other member of the immediate family where a visitation or parent-time right has been previously granted by the court, the court may award to the prevailing party costs, including actual attorney fees and court costs incurred by the prevailing party because of the other party's failure to provide or exercise court-ordered visitation or

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94	parent-time.
95	(8) (a) The court shall consider at least the following factors in determining alimony:
96	(i) the financial condition and needs of the recipient spouse;
97	(ii) the recipient's earning capacity or ability to produce income;
98	(iii) the ability of the payor spouse to provide support;
99	(iv) the length of the marriage;
100	(v) whether the recipient spouse has custody of minor children requiring support;
101	(vi) whether the recipient spouse worked in a business owned or operated by the payor
102	spouse; and
103	(vii) whether the recipient spouse directly contributed to any increase in the payor
104	spouse's skill by paying for education received by the payor spouse or allowing the payor
105	spouse to attend school during the marriage.
106	(b) The court may consider the fault of the parties in determining alimony.
107	(c) As a general rule, the court should look to the standard of living, existing at the
108	time of separation, in determining alimony in accordance with Subsection (8)(a). However, the
109	court shall consider all relevant facts and equitable principles and may, in its discretion, base
110	alimony on the standard of living that existed at the time of trial. In marriages of short
111	duration, when no children have been conceived or born during the marriage, the court may
112	consider the standard of living that existed at the time of the marriage.
113	(d) The court may, under appropriate circumstances, attempt to equalize the parties'
114	respective standards of living.
115	(e) When a marriage of long duration dissolves on the threshold of a major change in
116	the income of one of the spouses due to the collective efforts of both, that change shall be

the income of one of the spouses due to the collective efforts of both, that change shall be considered in dividing the marital property and in determining the amount of alimony. If one spouse's earning capacity has been greatly enhanced through the efforts of both spouses during the marriage, the court may make a compensating adjustment in dividing the marital property and awarding alimony.

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- (f) In determining alimony when a marriage of short duration dissolves, and no children have been conceived or born during the marriage, the court may consider restoring each party to the condition which existed at the time of the marriage.
 - (g) (i) The court has continuing jurisdiction to make substantive changes and new

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125	orders regarding alimony based on a substantial material change in circumstances not
126	foreseeable at the time of the divorce.
127	(ii) The court may not modify alimony or issue a new order for alimony to address
128	needs of the recipient that did not exist at the time the decree was entered, unless the court
129	finds extenuating circumstances that justify that action.
130	(iii) In determining alimony, the income of any subsequent spouse of the payor may not
131	be considered, except as provided in this Subsection (8).
132	(A) The court may consider the subsequent spouse's financial ability to share living
133	expenses.
134	(B) The court may consider the income of a subsequent spouse if the court finds that
135	the payor's improper conduct justifies that consideration.
136	(h) Alimony may not be ordered for a duration longer than the number of years that the
137	marriage existed unless, at any time prior to termination of alimony, the court finds extenuating
138	circumstances that justify the payment of alimony for a longer period of time.
139	(9) Unless a decree of divorce specifically provides otherwise, any order of the court
140	that a party pay alimony to a former spouse automatically terminates upon the remarriage or
141	death of that former spouse. However, if the remarriage is annulled and found to be void ab
142	initio, payment of alimony shall resume if the party paying alimony is made a party to the
143	action of annulment and his rights are determined.
144	(10) Any order of the court that a party pay alimony to a former spouse terminates
145	upon establishment by the party paying alimony that the former spouse is cohabitating with
146	another person.
147	Section 2. Section 30-3-5.5 is enacted to read:
148	30-3-5.5. Designation of Primary and Secondary Health, Dental or Hospital
149	Insurance Coverage.
150	(1) For purposes of this section, "health, hospital or dental insurance plan" has the
151	same meaning as "health care insurance" as defined in Section 31A-1-301.
152	(2) (a) A decree of divorce rendered in accordance with Section 30-3-5, an order for
153	medical expenses rendered in accordance with Section 78B-12-212, and an administrative
154	order under Section 62A-11-326 shall, in accordance with Subsection (2)(b)(ii), designate
155	which parent's health, hospital or dental insurance plan is primary coverage and which parent's

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156	health, hospital, or dental insurance plan is secondary coverage for a dependent child.
157	(b) The provisions of the court order required by Subsection (2)(a):
158	(i) shall take effect if at any time a dependent child is covered by both parents' health,
159	hospital, or dental insurance plans; and
160	(ii) shall include the following language:
161	"If, at any point in time, a dependent child is covered by the health, hospital, or dental
162	insurance plans of both parents, the health, hospital, or dental insurance plan of (Parent's
163	Name) shall be primary coverage for the dependent child and the health, hospital, or dental
164	insurance plan of (Other Parent's Name) shall be secondary coverage for the dependent child.
165	If a parent remarries and his or her dependent child is not covered by that parent's health,
166	hospital, or dental insurance plan but is covered by a step-parent's plan, the health, hospital, or
167	dental insurance plan of the step-parent shall be treated as if it is the plan of the remarried
168	parent and shall retain the same designation as the primary or secondary plan of the dependent
169	child."
170	(c) A decree of divorce or related court order may not modify the language required by
171	Subsection (2)(b)(ii).
172	(d) Notwithstanding Subsection (2)(c), a court may allocate the payment of medical
173	expenses including co-payments, deductibles, and co-insurance not covered by health insurance
174	between the parents in accordance with Subsections 30-3-5(1)(a) and 78B-12-212(6).
175	(2) In designating primary coverage pursuant to Subsection (2), a court may take into
176	account:
177	(a) the birth dates of the parents;
178	(b) a requirement in a court order, if any, for one of the parents to maintain health
179	insurance coverage for a dependent child;
180	(c) the parent with physical custody of the dependent child; or
181	(d) any other factor the court considers relevant.
182	Section 3. Section 31A-22-619 is amended to read:
183	31A-22-619. Coordination of benefits.
184	(1) The commissioner shall: [(a) convene a group of health insurers and health care
185	providers for the purpose of making recommendations to the Legislature regarding an efficient
186	method of coordination of benefits to increase the timeliness and accuracy of coordination of

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187	benefits;(b) report to the Legislature's Health Reform Task Force before November 15, 2009
188	regarding legislation to enact the recommendations developed under Subsection (1)(a); and (c)]
189	(a) adopt rules concerning the coordination of benefits between accident and health
190	insurance policies[-];
191	(b) publish a coordination of benefits guide;
192	(c) post the coordination of benefits guide on the state insurance exchange; and
193	(d) work with the Health Data Authority; health care provider groups, and with state
194	and national organizations that are developing uniform standards for the electronic exchange of
195	health insurance claims to develop standardized language regarding coordination of benefits for
196	the purpose of including the standardized language in an insurer's explanation of benefits.
197	(2) Rules adopted by the commissioner under Subsection (1):
198	(a) may not prohibit coordination of benefits with individual accident and health
199	insurance policies; [and]
200	(b) shall apply equally to all accident and health insurance policies without regard to
201	whether the policies are group or individual policies[7]; and
202	(c) shall include standardized language regarding the coordination of benefits process
203	that shall be included in each insurer's accident and health insurance policy.
204	Section 4. Section 62A-11-326 is amended to read:
205	62A-11-326. Medical and dental expenses of dependent children.
206	In any action under this part, the office and the department in their orders:
207	(1) shall include a provision assigning responsibility for cash medical support; and
208	(2) shall include a provision requiring the purchase and maintenance of appropriate
209	medical, hospital, and dental care insurance for those children, if:
210	(a) insurance coverage is or becomes available at a reasonable cost; and
211	(b) the insurance coverage is accessible to the children[-]; and
212	(3) shall include a designation of which health, dental or hospital insurance plan is
213	primary and which is secondary in accordance with the provisions of Section 30-3-5.5 which
214	will take effect if at any time the dependent children are covered by both parents' health,
215	hospital or dental insurance plans.
216	Section 5. Section 63I-2-231 is amended to read:
217	63I-2-231. Repeal dates, Title 31A.

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218	[(1)] Section 31A-23a-415 is repealed July 1, 2011.
219	[(2) Section 31A-22-619 is repealed July 1, 2010.]
220	Section 6. Section 78B-12-212 is amended to read:
221	78B-12-212. Medical expenses.
222	(1) (a) The court shall order that insurance for the medical expenses of the minor
223	children be provided by a parent if it is available at a reasonable cost.
224	(b) The court shall, in accordance with Section 30-3-5, designate which health,
225	hospital, or dental insurance plan is primary and which health, hospital, or dental insurance
226	plan is secondary if at any time a dependent child is covered by both parents' health, hospital or
227	dental insurance plans.
228	(2) In determining which parent shall be ordered to maintain insurance for medical
229	expenses, the court or administrative agency may consider the:
230	(a) reasonableness of the cost;
231	(b) availability of a group insurance policy;
232	(c) coverage of the policy; and
233	(d) preference of the custodial parent.
234	(3) The order shall require each parent to share equally the out-of-pocket costs of the
235	premium actually paid by a parent for the children's portion of insurance unless the court finds
236	good cause to order otherwise.
237	(4) The parent who provides the insurance coverage may receive credit against the base
238	child support award or recover the other parent's share of the children's portion of the premium.
239	In cases in which the parent does not have insurance but another member of the parent's
240	household provides insurance coverage for the children, the parent may receive credit against
241	the base child support award or recover the other parent's share of the children's portion of the
242	premium.
243	(5) The children's portion of the premium is a per capita share of the premium actually
244	paid. The premium expense for the children shall be calculated by dividing the premium
245	amount by the number of persons covered under the policy and multiplying the result by the
246	number of children in the instant case.
247	(6) The order shall, in accordance with Subsection 30-3-5 (1)(b), include a cash
248	medical support provision that requires each parent to equally share all reasonable and

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249 necessary uninsured and unreimbursed medical and dental expenses incurred for the dependent 250 children, including but not limited to deductibles and copayments unless the court finds good 251 cause to order otherwise. 252 (7) The parent ordered to maintain insurance shall provide verification of coverage to the other parent, or to the Office of Recovery Services under Title IV of the Social Security 253 254 Act, 42 U.S.C. Section 601 et seq., upon initial enrollment of the dependent children, and 255 thereafter on or before January 2 of each calendar year. The parent shall notify the other 256 parent, or the Office of Recovery Services under Title IV of the Social Security Act, 42 U.S.C. 257 Section 601 et seq., of any change of insurance carrier, premium, or benefits within 30 calendar 258 days of the date the parent first knew or should have known of the change. 259 (8) A parent who incurs medical expenses shall provide written verification of the cost 260 and payment of medical expenses to the other parent within 30 days of payment. 261 (9) In addition to any other sanctions provided by the court, a parent incurring medical 262 expenses may be denied the right to receive credit for the expenses or to recover the other 263 parent's share of the expenses if that parent fails to comply with Subsections (7) and (8). 264 Section 7. Repealer. 265 This bill repeals: 266 Section 31A-22-619.5 (Effective 07/01/10), Coordination of benefits.

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1	AMENDMENTS TO HEALTH INSURANCE	
2	COVERAGE IN STATE CONTRACTS	
3	2010 GENERAL SESSION	
4	STATE OF UTAH	
5	Y ONG TITE T	<u>, , ,</u>
6	LONG TITLE	
7	General Description:	
8	This bill amends provisions related to the requirement that contractors with certain the contractors with the certain the contractors with the certain the contractors with the certain the cert	
9	entities must provide qualified health insurance to their employees and the dependent	ndents
10	of the employees who work or reside in the state.	
11	Highlighted Provisions:	
12	This bill:	
13	 clarifies the application of a waiting period for health insurance may not exc 	eed the
14	first of the month following 90 days of the date of hire;	
15	 clarifies that the qualified health insurance coverage must be offered to empl 	loyees
16	and dependents who work or reside in the state;	
17	 clarifies that the qualified health insurance coverage that must be offered is a 	ì
18	minimum standard and an employer may offer greater coverage;	
19	amends the definition of qualified health insurance coverage to clarify the st	andards;
20	amends the enforcement provisions to provide protections for good faith	
21	compliance; and	
22	 clarifies how an employer offering a defined contribution arrangement may 	comply
23	with state contract requirements.	
24	Monies Appropriated in this Bill:	
25	None	
26	Other Special Clauses:	
27	None	
28	Utah Code Sections Affected:	
29	AMENDS:	
30	17B-2a-818.5, as enacted by Laws of Utah 2009, Chapter 13	
31	10-1-206 as enacted by I awa of Utah 2000 Chapter 12	

63A-5-205, as last amended by Laws of Utah 2009, Chapter 13
63C-9-403, as enacted by Laws of Utah 2009, Chapter 13
72-6-107.5, as enacted by Laws of Utah 2009, Chapter 13
79-2-404, as enacted by Laws of Utah 2009, Chapter 13
ENACTS:
31A-30-209 , Utah Code Annotated 1953
Be it enacted by the Legislature of the state of Utah:
Section 1. Section 17B-2a-818.5 is amended to read:
17B-2a-818.5. Contracting powers of public transit districts Health insurance
coverage.
(1) For purposes of this section:
(a) "Employee" means an "employee," "worker," or "operative" as defined in Section
34A-2-104 who:
(i) works at least 30 hours per calendar week; and
(ii) meets employer eligibility waiting requirements for health care insurance which
may not exceed the first day of the calendar month following 90 days from the date of hire.
(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
(c) "Qualified health insurance coverage" means [a health benefit plan that] at the time
the contract is entered into or renewed:
(i) [(A) provides coverage that is actuarially equivalent to the current benefit plan] a
health benefit plan and employer contribution level that provides coverage with an aggregate
actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance
organization that has the largest insured commercial, non-Medicaid, enrollment of covered
lives in the state, as determined by the Children's Health Insurance Program under [Section
26-40-106; and] Subsection 26-40-106(2)(a), in which:
[(B) under which] (A) the employer pays at least 50% of the premium for the
employee and the dependents of the employee[;] who reside or work in the state; and
(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):
(I) rather than the deductible and out of pocket maximum based on income levels, the
deductible is \$750 and the out of pocket maximum is \$3,000:

63	(II) dental coverage is not required; and
64	(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not
65	apply; or
66	(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:
67	(I) a deductible that is either:
68	[(1)] (Aa) the lowest deductible permitted for a federally qualified high deductible
69	health plan; [and] or
70	(Bb) a deductible that is higher than the lowest deductible permitted for a federally
71	qualified high deductible health plan, but includes an employer contribution to a health savings
72	account in a dollar amount at least equal to the dollar amount difference between the lowest
73	deductible permitted for a federally qualified high deductible plan and the deductible for the
74	employer offered federally qualified high deductible plan; and
75	(II) an out of pocket maximum that does not exceed three times the amount of the
76	annual deductible; and
77	(B) under which the employer pays 75% of the premium for the employee and the
78	dependents of the employee[; or] who work or reside in the state.
79	[(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan
80	determined under Subsection (1)(c)(i); and]
81	[(B) under which the employer pays at least 75% of the premium of the employee and
82	the dependents of the employee.]
83	(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
84	(2) Except as provided in Subsection (3), this section applies to all contracts entered
85	into by the public transit district on or after July 1, 2009, if:
86	(a) the contract is for design or construction; and
87	(b) (i) the prime contract is in the amount of \$1,500,000 or greater; or
88	(ii) a subcontract is in the amount of \$750,000 or greater.
89	(3) This section does not apply if:
90	(a) the application of this section jeopardizes the receipt of federal funds;
91	(b) the contract is a sole source contract; or
92	(c) the contract is an emergency procurement.
93	(4) (a) This section does not apply to a change order as defined in Section 63G-6-102,

or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

- 96 (b) A person who intentionally uses change orders or contract modifications to 97 circumvent the requirements of Subsection (2) is guilty of an infraction.
 - (5) (a) A contractor subject to Subsection (2) shall demonstrate to the public transit district that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employee's dependents during the duration of the contract.
 - (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor shall demonstrate to the public transit district that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employee's dependents during the duration of the contract.
 - (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with [administrative rules] an ordinance adopted by the public transit district under Subsection (6).
 - (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).
 - (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with [administrative rules] an ordinance adopted by the public transit district under Subsection (6).
 - (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).
 - (6) The public transit district shall adopt [administrative rules] ordinances:
- 117 [(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;]
- 118 [(b)] (a) in coordination with:

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- (i) the Department of Environmental Quality in accordance with Section 19-1-206;
- (ii) the Department of Natural Resources in accordance with Section 79-2-404;
- 121 (iii) the State Building Board in accordance with Section 63A-5-205;
- (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and
- (v) the Department of Transportation in accordance with Section 72-6-107.5; and
- 124 [(vi) the Legislature's Administrative Rules Review Committee; and]

125	[(c)] (b) which establish:
126	(i) the requirements and procedures a contractor must follow to demonstrate to the
127	public transit district compliance with this section which shall include:
128	(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) o
129	(b) more than twice in any 12-month period; and
130	(B) that the actuarially equivalent determination required in Subsection (1) is met by
131	the contractor if the contractor provides the department or division with a written statement of
132	actuarial equivalency from either the Utah Insurance Department or an actuary selected by the
133	contractor or the contractor's insurer; [and]
134	(ii) the penalties that may be imposed if a contractor or subcontractor intentionally
135	violates the provisions of this section, which may include:
136	(A) a three-month suspension of the contractor or subcontractor from entering into
137	future contracts with the public transit district upon the first violation;
138	(B) a six-month suspension of the contractor or subcontractor from entering into future
139	contracts with the public transit district upon the second violation;
140	(C) an action for debarment of the contractor or subcontractor in accordance with
141	Section 63G-6-804 upon the third or subsequent violation; and
142	(D) monetary penalties which may not exceed 50% of the amount necessary to
143	purchase qualified health insurance coverage for employees and dependents of employees of
144	the contractor or subcontractor who were not offered qualified health insurance coverage
145	during the duration of the contract[-]; and
146	(iii) a website on which the district shall post the benchmark for the qualified health
147	insurance coverage identified in Subsection (1)(c)(i).
148	(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
149	subcontractor who intentionally violates the provisions of this section shall be liable to the
150	employee for health care costs [not covered by insurance.] that would have been covered by
151	qualified health insurance coverage.
152	(ii) An employer has an affirmative defense to a cause of action under Subsection
153	(7)(a) if the employer:
154	(A) relied in good faith on a written statement of actuarial equivalency provided by an
155	actuary; or

156	(B) if a department or division determines that compliance with this section is not
157	required under the provisions of Subsections (3) or (4).
158	(b) An employee has a private right of action only against the employee's employer to
159	enforce the provisions of this Subsection (7).
160	(8) Any penalties imposed and collected under this section shall be deposited into the
161	Medicaid Restricted Account created in Section 26-18-402.
162	(9) The failure of a contractor or subcontractor to provide qualified health insurance
163	coverage as required by this section:
164	(a) may not be the basis for a protest or other action from a prospective bidder, offeror,
165	or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
166	Legal and Contractual Remedies; and
167	(b) may not be used by the procurement entity or a prospective bidder, offeror, or
168	contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
169	or construction.
170	Section 2. Section 19-1-206 is amended to read:
171	19-1-206. Contracting powers of department Health insurance coverage.
172	(1) For purposes of this section:
173	(a) "Employee" means an "employee," "worker," or "operative" as defined in Section
174	34A-2-104 who:
175	(i) works at least 30 hours per calendar week; and
176	(ii) meets employer eligibility waiting requirements for health care insurance which
177	may not exceed the first day of the calendar month following 90 days from the date of hire.
178	(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
179	(c) "Qualified health insurance coverage" means [a health benefit plan that] at the time
180	the contract is entered into or renewed:
181	(i) [(A) provides coverage that is actuarially equivalent to the current benefit plan] a
182	health benefit plan and employer contribution level that provides coverage with an aggregate
183	actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance
184	organization that has the largest insured commercial, non-Medicaid, enrollment of covered
185	lives in the state, as determined by the Children's Health Insurance Program under [Section
186	26-40-106; and] Subsection 26-40-106(2)(a),in which:

187	[(B) under which] (A) the employer pays at least 50% of the premium for the
188	employee and the dependents of the employee[;] who reside or work in the state; and
189	(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):
190	(I) rather than the deductible and out of pocket maximum based on income levels, the
191	deductible is \$750 and the out of pocket maximum is \$3,000;
192	(II) dental coverage is not required; and
193	(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not
194	apply; or
195	(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:
196	(I) a deductible that is either:
197	[(1)] (Aa) the lowest deductible permitted for a federally qualified high deductible
198	health plan; [and] or
199	(Bb) a deductible that is higher than the lowest deductible permitted for a federally
200	qualified high deductible health plan, but includes an employer contribution to a health savings
201	account in a dollar amount at least equal to the dollar amount difference between the lowest
202	deductible permitted for a federally qualified high deductible plan and the deductible for the
203	employer offered federally qualified high deductible plan; and
204	(II) an out of pocket maximum that does not exceed three times the amount of the
205	annual deductible; and
206	(B) under which the employer pays 75% of the premium for the employee and the
207	dependents of the employee[; or] who work or reside in the state.
208	[(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan
209	determined under Subsection (1)(c)(i); and]
210	[(B) under which the employer pays at least 75% of the premium of the employee and
211	the dependents of the employee.]
212	(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
213	(2) Except as provided in Subsection (3), this section applies to all contracts entered
214	into by or delegated to the department or a division or board of the department on or after July
215	1, 2009, if:
216	(a) the contract is for design or construction; and
217	(b) (i) the prime contract is in the amount of \$1,500,000 or greater; or

218	(ii) a subcontract is in the amount of \$750,000 or greater.
219	(3) This section does not apply to contracts entered into by the department or a division
220	or board of the department if:
221	(a) the application of this section jeopardizes the receipt of federal funds;
222	(b) the contract or agreement is between:
223	(i) the department or a division or board of the department; and
224	(ii) (A) another agency of the state;
225	(B) the federal government;
226	(C) another state;
227	(D) an interstate agency;
228	(E) a political subdivision of this state; or
229	(F) a political subdivision of another state;
230	(c) the executive director determines that applying the requirements of this section to a
231	particular contract interferes with the effective response to an immediate health and safety
232	threat from the environment; or
233	(d) the contract is:
234	(i) a sole source contract; or
235	(ii) an emergency procurement.
236	(4) (a) This section does not apply to a change order as defined in Section 63G-6-102,
237	or a modification to a contract, when the contract does not meet the initial threshold required
238	by Subsection (2).
239	(b) A person who intentionally uses change orders or contract modifications to
240	circumvent the requirements of Subsection (2) is guilty of an infraction.
241	(5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
242	director that the contractor has and will maintain an offer of qualified health insurance
243	coverage for the contractor's employees and the employees' dependents during the duration of
244	the contract.
245	(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
246	demonstrate to the executive director that the subcontractor has and will maintain an offer of
247	qualified health insurance coverage for the subcontractor's employees and the employees'
248	dependents during the duration of the contract,

249	(c) (i) (A) A contractor who fails to comply with Subsection (5)(a) during the duration
250	of the contract is subject to penalties in accordance with administrative rules adopted by the
251	department under Subsection (6).
252	(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
253	requirements of Subsection (5)(b).
254	(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
255	the duration of the contract is subject to penalties in accordance with administrative rules
256	adopted by the department under Subsection (6).
257	(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
258	requirements of Subsection (5)(a).
259	(6) The department shall adopt administrative rules:
260	(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
261	(b) in coordination with:
262	(i) a public transit district in accordance with Section 17B-2a-818.5;
263	(ii) the Department of Natural Resources in accordance with Section 79-2-404;
264	(iii) the State Building Board in accordance with Section 63A-5-205;
265	(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
266	(v) the Department of Transportation in accordance with Section 72-6-107.5; and
267	(vi) the Legislature's Administrative Rules Review Committee; and
268	(c) which establish:
269	(i) the requirements and procedures a contractor must follow to demonstrate to the
270	public transit district compliance with this section which shall include:
271	(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
272	(b) more than twice in any 12-month period; and
273	(B) that the actuarially equivalent determination required in Subsection (1) is met by
274	the contractor if the contractor provides the department or division with a written statement of
275	actuarial equivalency from either the Utah Insurance Department or an actuary selected by the
276	contractor or the contractor's insurer; [and]
277	(ii) the penalties that may be imposed if a contractor or subcontractor intentionally
278	violates the provisions of this section, which may include:
279	(A) a three-month suspension of the contractor or subcontractor from entering into

280	future contracts with the state upon the first violation;
281	(B) a six-month suspension of the contractor or subcontractor from entering into future
282	contracts with the state upon the second violation;
283	(C) an action for debarment of the contractor or subcontractor in accordance with
284	Section 63G-6-804 upon the third or subsequent violation; and
285	(D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50%
286	of the amount necessary to purchase qualified health insurance coverage for an employee and
287	the dependents of an employee of the contractor or subcontractor who was not offered qualified
288	health insurance coverage during the duration of the contract[-]; and
289	(iii) a website on which the department shall post the benchmark for the qualified
290	health insurance coverage identified in Subsection (1)(c)(i).
291	(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
292	subcontractor who intentionally violates the provisions of this section shall be liable to the
293	employee for health care costs [not covered by insurance.] that would have been covered by
294	qualified health insurance coverage.
295	(ii) An employer has an affirmative defense to a cause of action under Subsection
296	(7)(a) if the employer:
297	(A) relied in good faith on a written statement of actuarial equivalency provided by an
298	actuary; or
299	(B) if the department determines that compliance with this section is not required under
300	the provisions of Subsections (3) or (4).
30 1	(b) An employee has a private right of action only against the employee's employer to
302	enforce the provisions of this Subsection (7).
303	(8) Any penalties imposed and collected under this section shall be deposited into the
304	Medicaid Restricted Account created in Section 26-18-402.
305	(9) The failure of a contractor or subcontractor to provide qualified health insurance
306	coverage as required by this section:
307	(a) may not be the basis for a protest or other action from a prospective bidder, offeror,
308	or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
309	Legal and Contractual Remedies; and
310	(b) may not be used by the procurement entity or a prospective bidder, offeror, or

311	contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
312	or construction.
313	Section 3. Section 31A-30-209 is enacted to read:
314	31A-30-209. State contract requirements Employer default plans.
315	(1) This section applies to an employer who is required to offer its employees a health
316	benefit plan as a condition of qualifying for a state contract under:
317	(a) Section 17B-2a-818.5;
318	(b) Section 19-1-206;
319	(c) Subsection 53A-5-205(3);
320	(d) Section 63C-9-403;
321	(e) Section 72-6-107.5; and
322	(f) Section 79-2-404.
323	(2) An employer described in Subsection (1) shall, when selecting the default plan
324	required in Section 31A-30-204, select a default plan that is "qualified health insurance
325	coverage" as defined in the sections listed in Subsections (1)(a) through (f).
326	Section 4. Section 63A-5-205 is amended to read:
327	63A-5-205. Contracting powers of director Retainage Health insurance
328	coverage.
329	(1) As used in this section:
330	(a) "Capital developments" has the same meaning as provided in Section 63A-5-104.
331	(b) "Capital improvements" has the same meaning as provided in Section 63A-5-104.
332	(c) "Employee" means an "employee," "worker," or "operative" as defined in Section
333	34A-2-104 who:
334	(i) works at least 30 hours per calendar week; and
335	(ii) meets employer eligibility waiting requirements for health care insurance which
336	may not exceed the first day of the calendar month following 90 days from the date of hire.
337	(d) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
338	(e) "Qualified health insurance coverage" means [a health benefit plan that] at the time
339	the contract is entered into or renewed:
340	(i) [(A) provides coverage that is actuarially equivalent to the current benefit plan] a
341	health benefit plan and employer contribution level that provides coverage with an aggregate

342	actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance
343	organization that has the largest insured commercial, non-Medicaid, enrollment of covered
344	lives in the state, as determined by the Children's Health Insurance Program under [Section
345	26-40-106; and] Subsection 26-40-106(2)(a) in which:
346	[(B) under which] (A) the employer pays at least 50% of the premium for the
347	employee and the dependents of the employee[;] who work and reside in the state; and
348	(B) for purposes of calculating actuarial equivalency under this Subsection (1)(e)(i):
349	(I) rather than the deductible and out of pocket maximum based on income levels, the
350	deductible is \$750 and the out of pocket maximum is \$3,000;
351	(II) dental coverage is not required; and
352	(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not
353	apply; or
354	(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:
355	(I) a deductible that is either:
356	[(1)] (Aa) the lowest deductible permitted for a federally qualified high deductible
357	health plan; [and] or
358	(Bb) a deductible that is higher than the lowest deductible permitted for a federally
359	qualified high deductible health plan, but includes an employer contribution to a health savings
360	account in a dollar amount at least equal to the dollar amount difference between the lowest
361	deductible permitted for a federally qualified high deductible plan and the deductible for the
362	employer offered federally qualified high deductible plan; and
363	(II) an out of pocket maximum that does not exceed three times the amount of the
364	annual deductible; and
365	(B) under which the employer pays 75% of the premium for the employee and the
366	dependents of the employee[; or] who work or reside in the state.
367	[(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan
368	determined under Subsection (1)(e)(i); and]
369	[(B) under which the employer pays at least 75% of the premium of the employee and
370	the dependents of the employee.]
371	(f) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
372	(2) In accordance with Title 63G, Chapter 6, Utah Procurement Code, the director may:

373	(a) subject to Subsection (3), enter into contracts for any work or professional services
374	which the division or the State Building Board may do or have done; and
375	(b) as a condition of any contract for architectural or engineering services, prohibit the
376	architect or engineer from retaining a sales or agent engineer for the necessary design work.
377	(3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all
378	contracts entered into by the division or the State Building Board on or after July 1, 2009, if:
379	(i) the contract is for design or construction; and
380	(ii) (A) the prime contract is in the amount of \$1,500,000 or greater; or
381	(B) a subcontract is in the amount of \$750,000 or greater.
382	(b) This Subsection (3) does not apply:
383	(i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;
384	(ii) if the contract is a sole source contract;
385	(iii) if the contract is an emergency procurement; or
386	(iv) to a change order as defined in Section 63G-6-102, or a modification to a contract,
387	when the contract does not meet the threshold required by Subsection (3)(a).
388	(c) A person who intentionally uses change orders or contract modifications to
389	circumvent the requirements of Subsection (3)(a) is guilty of an infraction.
390	(d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that
391	the contractor has and will maintain an offer of qualified health insurance coverage for the
392	contractor's employees and the employees' dependents.
393	(ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor
394	shall demonstrate to the director that the subcontractor has and will maintain an offer of
395	qualified health insurance coverage for the subcontractor's employees and the employees'
396	dependents.
397	(e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i)
398	during the duration of the contract is subject to penalties in accordance with administrative
399	rules adopted by the division under Subsection (3)(f).
400	(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
401	requirements of Subsection (3)(d)(ii).
402	(ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii)
403	during the duration of the contract is subject to penalties in accordance with administrative

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404	rules adopted by the division under Subsection (3)(f).
405	(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
406	requirements of Subsection (3)(d)(i).
407	(f) The division shall adopt administrative rules:
408	(i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
409	(ii) in coordination with:
410	(A) the Department of Environmental Quality in accordance with Section 19-1-206;
411	(B) the Department of Natural Resources in accordance with Section 79-2-404;
412	(C) a public transit district in accordance with Section 17B-2a-818.5;
413	(D) the State Capitol Preservation Board in accordance with Section 63C-9-403;
414	(E) the Department of Transportation in accordance with Section 72-6-107.5; and
415	(F) the Legislature's Administrative Rules Review Committee; and
416	(iii) which establish:
417	(A) the requirements and procedures a contractor must follow to demonstrate to the
418	director compliance with this Subsection (3) which shall include:
419	(I) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
420	(b) more than twice in any 12-month period; and
421	(II) that the actuarially equivalent determination required in Subsection (1) is met by
422	the contractor if the contractor provides the department or division with a written statement of
423	actuarial equivalency from either the Utah Insurance Department or an actuary selected by the
424	contractor or the contractor's insurer; [and]
425	(B) the penalties that may be imposed if a contractor or subcontractor intentionally
426	violates the provisions of this Subsection (3), which may include:
427	(I) a three-month suspension of the contractor or subcontractor from entering into
428	future contracts with the state upon the first violation;
429	(II) a six-month suspension of the contractor or subcontractor from entering into future
430	contracts with the state upon the second violation;
431	(III) an action for debarment of the contractor or subcontractor in accordance with
432	Section 63G-6-804 upon the third or subsequent violation; and
433	(IV) monetary penalties which may not exceed 50% of the amount necessary to
434	purchase qualified health insurance coverage for an employee and the dependents of an

435	employee of the contractor or subcontractor who was not offered qualified health insurance
436	coverage during the duration of the contract[-]; and
437	(C) a website on which the department shall post the benchmark for the qualified
438	health insurance coverage identified in Subsection (1)(e)(i).
439	(g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or
440	subcontractor who intentionally violates the provisions of this section shall be liable to the
441	employee for health care costs [not covered by insurance.] that would have been covered by
442	qualified health insurance coverage.
443	(ii) An employer has an affirmative defense to a cause of action under Subsection (g)(i)
444	if the employer:
445	(A) relied in good faith on a written statement of actuarial equivalency provided by an
446	actuary; or
447	(B) if the department determines that compliance with this section is not required under
448	the provisions of Subsection (3)(b).
449	[(ii)] (iii) An employee has a private right of action only against the employee's
450	employer to enforce the provisions of this Subsection (3)(g).
451	(h) Any penalties imposed and collected under this section shall be deposited into the
452	Medicaid Restricted Account created by Section 26-18-402.
453	(i) The failure of a contractor or subcontractor to provide qualified health insurance
454	coverage as required by this section:
455	(i) may not be the basis for a protest or other action from a prospective bidder, offeror,
456	or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
457	Legal and Contractual Remedies; and
458	(ii) may not be used by the procurement entity or a prospective bidder, offeror, or
459	contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
460	or construction.
461	(4) The judgment of the director as to the responsibility and qualifications of a bidder
462	is conclusive, except in case of fraud or bad faith.
463	(5) The division shall make all payments to the contractor for completed work in
464	accordance with the contract and pay the interest specified in the contract on any payments that
465	are late.

466	(6) If any payment on a contract with a private contractor to do work for the division or
467	the State Building Board is retained or withheld, it shall be retained or withheld and released as
468	provided in Section 13-8-5.
469	Section 5. Section 63C-9-403 is amended to read:
470	63C-9-403. Contracting power of executive director Health insurance coverage.
471	(1) For purposes of this section:
472	(a) "Employee" means an "employee," "worker," or "operative" as defined in Section
473	34A-2-104 who:
474	(i) works at least 30 hours per calendar week; and
475	(ii) meets employer eligibility waiting requirements for health care insurance which
476	may not exceed the first of the calendar month following 90 days from the date of hire.
477	(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
478	(c) "Qualified health insurance coverage" means [a health benefit plan that] at the time
479	the contract is entered into or renewed:
480	(i) [(A) provides coverage that is actuarially equivalent to the current benefit plan] \underline{a}
481	health benefit plan and employer contribution level that provides coverage with an aggregate
482	actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance
483	organization that has the largest insured commercial, non-Medicaid, enrollment of covered
484	lives in the state, as determined by the Children's Health Insurance Program under [Section
485	26-40-106; and] <u>Subsection 26-40-106(2)(a), in which:</u>
486	[(B) under which] (A) the employer pays at least 50% of the premium for the
487	employee and the dependents of the employee[;] who work or reside in the state; and
488	(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):
489	(I) rather than the deductible and out of pocket maximum based on income levels, the
490	deductible is \$750 and the out of pocket maximum is \$3,000;
491	(II) dental coverage is not required; and
492	(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not
493	apply; or
494	(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:
495	(I) a deductible that is either:
496	[(1)] (Aa) the lowest deductible permitted for a federally qualified high deductible

497	health plan; [and] or
498	(Bb) a deductible that is higher than the lowest deductible permitted for a federally
499	qualified high deductible health plan, but includes an employer contribution to a health savings
500	account in a dollar amount at least equal to the dollar amount difference between the lowest
501	deductible permitted for a federally qualified high deductible plan and the deductible for the
502	employer offered federally qualified high deductible plan; and
503	(II) an out of pocket maximum that does not exceed three times the amount of the
504	annual deductible; and
505	(B) under which the employer pays 75% of the premium for the employee and the
506	dependents of the employee[; or] who work or reside in the state.
507	[(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan
508	determined under Subsection (1)(c)(i); and]
509	[(B) under which the employer pays at least 75% of the premium of the employee and
510	the dependents of the employee.]
511	(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
512	(2) Except as provided in Subsection (3), this section applies to all contracts entered
513	into by the board or on behalf of the board on or after July 1, 2009, if:
514	(a) the contract is for design or construction; and
515	(b) (i) the prime contract is in the amount of \$1,500,000 or greater; or
516	(ii) a subcontract is in the amount of \$750,000 or greater.
517	(3) This section does not apply if:
518	(a) the application of this section jeopardizes the receipt of federal funds;
519	(b) the contract is a sole source contract; or
520	(c) the contract is an emergency procurement.
521	(4) (a) This section does not apply to a change order as defined in Section 63G-6-102,
522	or a modification to a contract, when the contract does not meet the initial threshold required
523	by Subsection (2).
524	(b) A person who intentionally uses change orders or contract modifications to
525	circumvent the requirements of Subsection (2) is guilty of an infraction.
526	(5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive
527	director that the contractor has and will maintain an offer of qualified health insurance

528 coverage for the contractor's employees and the employees' dependents during the duration of 529 the contract. 530 (b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor 531 shall demonstrate to the executive director that the subcontractor has and will maintain an offer 532 of qualified health insurance coverage for the subcontractor's employees and the employees' 533 dependents during the duration of the contract, 534 (c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during 535 the duration of the contract is subject to penalties in accordance with administrative rules 536 adopted by the division under Subsection (6). 537 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the 538 requirements of Subsection (5)(b). 539 (ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during 540 the duration of the contract is subject to penalties in accordance with administrative rules 541 adopted by the department under Subsection (6). 542 (B) A subcontractor is not subject to penalties for the failure of a contractor to meet the 543 requirements of Subsection (5)(a). 544 (6) The department shall adopt administrative rules: 545 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act: 546 (b) in coordination with: 547 (i) the Department of Environmental Quality in accordance with Section 19-1-206; 548 (ii) the Department of Natural Resources in accordance with Section 79-2-404; 549 (iii) the State Building Board in accordance with Section 63A-5-205; 550 (iv) a public transit district in accordance with Section 17B-2a-818.5; 551 (v) the Department of Transportation in accordance with Section 72-6-107.5; and 552 (vi) the Legislature's Administrative Rules Review Committee; and 553 (c) which establish: 554 (i) the requirements and procedures a contractor must follow to demonstrate to the 555 executive director compliance with this section which shall include: 556 (A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or 557 (b) more than twice in any 12-month period; and 558 (B) that the actuarially equivalent determination required in Subsection (1) is met by

559	the contractor if the contractor provides the department or division with a written statement of
560	actuarial equivalency from either the Utah Insurance Department or an actuary selected by the
561	contractor or the contractor's insurer; [and]
562	(ii) the penalties that may be imposed if a contractor or subcontractor intentionally
563	violates the provisions of this section, which may include:
564	(A) a three-month suspension of the contractor or subcontractor from entering into
565	future contracts with the state upon the first violation;
566	(B) a six-month suspension of the contractor or subcontractor from entering into future
567	contracts with the state upon the second violation;
568	(C) an action for debarment of the contractor or subcontractor in accordance with
569	Section 63G-6-804 upon the third or subsequent violation; and
570	(D) monetary penalties which may not exceed 50% of the amount necessary to
57 1	purchase qualified health insurance coverage for employees and dependents of employees of
572	the contractor or subcontractor who were not offered qualified health insurance coverage
573	during the duration of the contract[-]; and
574	(iii) a website on which the department shall post the benchmark for the qualified
575	health insurance coverage identified in Subsection (1)(c)(i).
576	(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or
.577	subcontractor who intentionally violates the provisions of this section shall be liable to the
578	employee for health care costs [not covered by insurance.] that would have been covered by
579	qualified health insurance coverage.
580	(ii) An employer has an affirmative defense to a cause of action under Subsection
581	(7)(a) if the employer:
582	(A) relied in good faith on a written statement of actuarial equivalency provided by an
583	actuary; or
584	(B) if the department determines that compliance with this section is not required under
585	the provisions of Subsections (3) or (4).
586	(b) An employee has a private right of action only against the employee's employer to
587	enforce the provisions of this Subsection (7).
588	(8) Any penalties imposed and collected under this section shall be deposited into the
589	Medicaid Restricted Account created in Section 26-18-402.

590	(9) The failure of a contractor or subcontractor to provide qualified health insurance
591	coverage as required by this section:
592	(a) may not be the basis for a protest or other action from a prospective bidder, offeror
593	or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
594	Legal and Contractual Remedies; and
595	(b) may not be used by the procurement entity or a prospective bidder, offeror, or
596	contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
597	or construction.
598	Section 6. Section 72-6-107.5 is amended to read:
599	72-6-107.5. Construction of improvements of highway Contracts Health
600	insurance coverage.
601	(1) For purposes of this section:
602	(a) "Employee" means an "employee," "worker," or "operative" as defined in Section
603	34A-2-104 who:
604	(i) works at least 30 hours per calendar week; and
605	(ii) meets employer eligibility waiting requirements for health care insurance which
606	may not exceed the first day of the calendar month following 90 days from the date of hire.
607	(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.
608	(c) "Qualified health insurance coverage" means [a health benefit plan that] at the time
609	the contract is entered into or renewed:
610	(i) [(A) provides coverage that is actuarially equivalent to the current benefit plan] a
611	health benefit plan and employer contribution level that provides coverage with an aggregate
612	actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance
613	organization that has the largest insured commercial, non-Medicaid, enrollment of covered
614	lives in the state, as determined by the Children's Health Insurance Program under [Section
615	26-40-106; and] <u>Subsection 26-40-106(2)(a), in which:</u>
616	[(B) under which] (A) the employer pays at least 50% of the premium for the
617	employee and the dependents of the employee[;] who work or reside in the state; and
618	(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):
619	(I) rather than the deductible and out of pocket maximum based on income levels, the
620	deductible is \$750 and the out of pocket maximum is \$3,000;

621	(II) dental coverage is not required; and
622	(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not
623	apply; or
624	(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:
625	(I) a deductible that is either:
626	[(1)] (Aa) the lowest deductible permitted for a federally qualified high deductible
627	health plan; [and] or
628	(Bb) a deductible that is higher than the lowest deductible permitted for a federally
629	qualified high deductible health plan, but includes an employer contribution to a health savings
630	account in a dollar amount at least equal to the dollar amount difference between the lowest
631	deductible permitted for a federally qualified high deductible plan and the deductible for the
632	employer offered federally qualified high deductible plan; and
633	(II) an out of pocket maximum that does not exceed three times the amount of the
634	annual deductible; and
635	(B) under which the employer pays 75% of the premium for the employee and the
636	dependents of the employee[; or] who reside or work in the state.
637	[(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan
638	determined under Subsection (1)(c)(i); and]
639	[(B) under which the employer pays at least 75% of the premium of the employee and
640	the dependents of the employee.]
641	(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
642	(2) Except as provided in Subsection (3), this section applies to all contracts entered
643	into by the department on or after July 1, 2009, for construction or design of highways if:
644	(a) the prime contract is in the amount of \$1,500,000 or greater; or
645	(b) a subcontract is in the amount of \$750,000 or greater.
646	(3) This section does not apply if:
647	(a) the application of this section jeopardizes the receipt of federal funds;
648	(b) the contract is a sole source contract; or
649	(c) the contract is an emergency procurement.
650	(4) (a) This section does not apply to a change order as defined in Section 63G-6-102,
651	or a modification to a contract, when the contract does not meet the initial threshold required

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652	by Subsection (2).
653	(b) A person who intentionally uses change orders or contract modifications to
654	circumvent the requirements of Subsection (2) is guilty of an infraction.
655	(5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that
656	the contractor has and will maintain an offer of qualified health insurance coverage for the
657	contractor's employees and the employees' dependents during the duration of the contract.
658	(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall
659	demonstrate to the department that the subcontractor has and will maintain an offer of qualified
660	health insurance coverage for the subcontractor's employees and the employees' dependents
661	during the duration of the contract.
662	(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during
663	the duration of the contract is subject to penalties in accordance with administrative rules
664	adopted by the department under Subsection (6).
665	(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the
666	requirements of Subsection (5)(b).
667	(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
668	the duration of the contract is subject to penalties in accordance with administrative rules
669	adopted by the department under Subsection (6).
670	(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
67 1	requirements of Subsection (5)(a).
672	(6) The department shall adopt administrative rules:
673	(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
674	(b) in coordination with:
675	(i) the Department of Environmental Quality in accordance with Section 19-1-206;

- 676 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
- 677 (iii) the State Building Board in accordance with Section 63A-5-205;
- 678 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
- 679 (v) a public transit district in accordance with Section 17B-2a-818.5; and
- (vi) the Legislature's Administrative Rules Review Committee; and 680
- 681 (c) which establish:
- 682 (i) the requirements and procedures a contractor must follow to demonstrate to the

683	department compliance with this section which shall include:
684	(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
685	(b) more than twice in any 12-month period; and
686	(B) that the actuarially equivalent determination required in Subsection (1) is met by
687	the contractor if the contractor provides the department or division with a written statement of
688	actuarial equivalency from either the Utah Insurance Department or an actuary selected by the
689	contractor or the contractor's insurer; [and]
690	(ii) the penalties that may be imposed if a contractor or subcontractor intentionally
691	violates the provisions of this section, which may include:
692	(A) a three-month suspension of the contractor or subcontractor from entering into
693	future contracts with the state upon the first violation;
694	(B) a six-month suspension of the contractor or subcontractor from entering into future
695	contracts with the state upon the second violation;
696	(C) an action for debarment of the contractor or subcontractor in accordance with
697	Section 63G-6-804 upon the third or subsequent violation; and
698	(D) monetary penalties which may not exceed 50% of the amount necessary to
699	purchase qualified health insurance coverage for an employee and a dependent of the employee
700	of the contractor or subcontractor who was not offered qualified health insurance coverage
701	during the duration of the contract[-]; and
702	(iii) a website on which th department shall post the benchmark for the qualified health
703	insurance coverage identified in Subsection (1)(c)(i).
704	(7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
705	subcontractor who intentionally violates the provisions of this section shall be liable to the
706	employee for health care costs [not covered by insurance.] that would have been covered by
707	qualified health insurance coverage.
708	(ii) An employer has an affirmative defense to a cause of action under Subsection
709	(7)(a) if the employer:
710	(A) relied in good faith on a written statement of actuarial equivalency provided by an
711	actuary; or
712	(B) if the department determines that compliance with this section is not required under
713	the provisions of Subsections (3) or (4).

714 (b) An employee has a private right of action only against the employee's employer to 715 enforce the provisions of this Subsection (7). 716 (8) Any penalties imposed and collected under this section shall be deposited into the 717 Medicaid Restricted Account created in Section 26-18-402. 718 (9) The failure of a contractor or subcontractor to provide qualified health insurance 719 coverage as required by this section: 720 (a) may not be the basis for a protest or other action from a prospective bidder, offeror, 721 or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8, 722 Legal and Contractual Remedies; and 723 (b) may not be used by the procurement entity or a prospective bidder, offeror, or 724 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design 725 or construction. 726 Section 7. Section 79-2-404 is amended to read: 727 79-2-404. Contracting powers of department -- Health insurance coverage. 728 (1) For purposes of this section: 729 (a) "Employee" means an "employee," "worker," or "operative" as defined in Section 730 34A-2-104 who: 731 (i) works at least 30 hours per calendar week; and 732 (ii) meets employer eligibility waiting requirements for health care insurance which 733 may not exceed the first day of the calendar month following 90 days from the date of hire. 734 (b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301. 735 (c) "Qualified health insurance coverage" means a [health benefit plan that] at the time 736 the contract is entered into or renewed: 737 (i) [(A) provides coverage that is actuarially equivalent to the current benefit plan] a 738 health benefit plan and employer contribution level that provides coverage with an aggregate 739 actuarial value at least actuarially equivalent to the plan that is offered by a health maintenance 740 organization that has the largest insured commercial, non-Medicaid, enrollment of covered 741 lives in the state, as determined by the Children's Health Insurance Program under [Section 742 26-40-106; and] Subsection 26-40-106(2)(a) in which:

(B) under which (A) the employer pays at least 50% of the premium for the

employee and the dependents of the employee[7] who reside or work in the state; and

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745	(B) for purposes of calculating actuarial equivalency under this Subsection (1)(c)(i):
746	(I) rather than the deductible and out of pocket maximum based on income levels, the
747	deductible is \$750 and the out of pocket maximum is \$3,000;
748	(II) dental coverage is not required; and
749	(III) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not
750	apply; or
751	(ii) (A) is a federally qualified high deductible health plan that, at a minimum, has:
752	(I) a deductible that is either:
753	[(1)] (Aa) the lowest deductible permitted for a federally qualified high deductible
754	health plan; [and] or
755	(Bb) a deductible that is higher than the lowest deductible permitted for a federally
756	qualified high deductible health plan, but includes an employer contribution to a health savings
757	account in a dollar amount at least equal to the dollar amount difference between the lowest
758	deductible permitted for a federally qualified high deductible plan and the deductible for the
759	employer offered federally qualified high deductible plan; and
760	(II) an out of pocket maximum that does not exceed three times the amount of the
76 1	annual deductible; and
762	(B) under which the employer pays 75% of the premium for the employee and the
763	dependents of the employee[; or] who work or reside in the state.
764	[(iii) (A) provides coverage that is actuarially equivalent to 75% of the benefit plan
765	determined under Subsection (1)(e)(i); and]
766	[(B) under which the employer pays at least 75% of the premium of the employee and
767	the dependents of the employee.]
768	(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.
769	(2) Except as provided in Subsection (3), this section applies to all contracts entered
770	into by, or delegated to, the department or a division, board, or council of the department on or
771	after July 1, 2009, if:
772	(a) the contract is for design or construction; and
773	(b) (i) the prime contract is in the amount of \$1,500,000 or greater; or
774	(ii) a subcontract is in the amount of \$750,000 or greater.
775	(3) This section does not apply to contracts entered into by the department or a

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776	division, board, or council of the department if:
777	(a) the application of this section jeopardizes the receipt of federal funds;
778	(b) the contract or agreement is between:
779	(i) the department or a division, board, or council of the department; and
780	(ii) (A) another agency of the state;
781	(B) the federal government;
782	(C) another state;
783	(D) an interstate agency;
784	(E) a political subdivision of this state; or
785	(F) a political subdivision of another state; or
786	(c) the contract or agreement is:
787	(i) for the purpose of disbursing grants or loans authorized by statute;
788	(ii) a sole source contract; or
789	(iii) an emergency procurement.
790	(4) (a) This section does not apply to a change order as defined in Section 63G-6-102,
791	or a modification to a contract, when the contract does not meet the initial threshold required
792	by Subsection (2).
793	(b) A person who intentionally uses change orders or contract modifications to
794	circumvent the requirements of Subsection (2) is guilty of an infraction.
795	(5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department
796	that the contractor has and will maintain an offer of qualified health insurance coverage for the
797	contractor's employees and the employees' dependents during the duration of the contract.
798	(b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor
799	shall demonstrate to the department that the subcontractor has and will maintain an offer of
800	qualified health insurance coverage for the subcontractor's employees and the employees'
801	dependents during the duration of the contract.
802	(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

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805 (B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

807	(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during
808	the duration of the contract is subject to penalties in accordance with administrative rules
809	adopted by the department under Subsection (6).
810	(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the
811	requirements of Subsection (5)(a).
812	(6) The department shall adopt administrative rules:
813	(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
814	(b) in coordination with:
815	(i) the Department of Environmental Quality in accordance with Section 19-1-206;
816	(ii) a public transit district in accordance with Section 17B-2a-818.5;
817	(iii) the State Building Board in accordance with Section 63A-5-205;
818	(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
819	(v) the Department of Transportation in accordance with Section 72-6-107.5; and
820	(vi) the Legislature's Administrative Rules Review Committee; and
821	(c) which establish:
822	(i) the requirements and procedures a contractor must follow to demonstrate
823	compliance with this section to the department which shall include:
824	(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or
825	(b) more than twice in any 12-month period; and
826	(B) that the actuarially equivalent determination required in Subsection (1) is met by
827	the contractor if the contractor provides the department or division with a written statement of
828	actuarial equivalency from either the Utah Insurance Department or an actuary selected by the
829	contractor or the contractor's insurer; and
830	(ii) the penalties that may be imposed if a contractor or subcontractor intentionally
831	violates the provisions of this section, which may include:
832	(A) a three-month suspension of the contractor or subcontractor from entering into
833	future contracts with the state upon the first violation;
834	(B) a six-month suspension of the contractor or subcontractor from entering into future
835	contracts with the state upon the second violation;
836	(C) an action for debarment of the contractor or subcontractor in accordance with
837	Section 63G-6-804 upon the third or subsequent violation; [and]

838	(D) monetary penalties which may not exceed 50% of the amount necessary to
839	purchase qualified health insurance coverage for an employee and a dependent of an employee
840	of the contractor or subcontractor who was not offered qualified health insurance coverage
841	during the duration of the contract[-]; and
842	(iii) a website on which the department shall post the benchmark for the qualified
843	health insurance coverage identified in Subsection (1)(c)(i).
844	(7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or
845	subcontractor who intentionally violates the provisions of this section shall be liable to the
846	employee for health care costs [not covered by insurance.] that would have been covered by
847	qualified health insurance coverage.
848	(ii) An employer has an affirmative defense to a cause of action under Subsection
849	(7)(a) if the employer:
850	(A) relied in good faith on a written statement of actuarial equivalency provided by an
851	actuary; or
852	(B) if the department determines that compliance with this section is not required under
853	the provisions of Subsections (3) or (4).
854	(b) An employee has a private right of action only against the employee's employer to
855	enforce the provisions of this Subsection (7).
856	(8) Any penalties imposed and collected under this section shall be deposited into the
857	Medicaid Restricted Account created in Section 26-18-402.
858	(9) The failure of a contractor or subcontractor to provide qualified health insurance
859	coverage as required by this section:
860	(a) may not be the basis for a protest or other action from a prospective bidder, offeror,
861	or contractor under Section 63G-6-801 or any other provision in Title 63G, Chapter 6, Part 8,
862	Legal and Contractual Remedies; and
863	(b) may not be used by the procurement entity or a prospective bidder, offeror, or
864	contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
865	or construction.

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2010FL-0431/007

1	HEALTH REFORM - UNIFORM ELECTRONIC
2	STANDARDS - INSURANCE INFORMATION
3	2010 GENERAL SESSION
4	STATE OF UTAH
5	
6	LONG TITLE
7	General Description:
8	This bill amends provisions related to the use of uniform electronic standards for health
9	insurance claims processing, insurance eligibility, and coordination of benefits.
10	Highlighted Provisions:
11	This bill:
12	 amends provisions related to uniform electronic standards for health insurance
13	claims processing, electronic insurance eligibility information, and electronic
14	information regarding the coordination of benefits;
15	 establishes a voluntary registry of software vendors who comply with electronic
16	standards; and
17	 makes clarifying and technical amendments.
18	Monies Appropriated in this Bill:
19	None
20	Other Special Clauses:
21	This bill takes effect on July 1, 2010.
22	Utah Code Sections Affected:
23	AMENDS:
24	31A-22-614.5, as last amended by Laws of Utah 2008, Chapters 379 and 382
25	
26	Be it enacted by the Legislature of the state of Utah:
27	Section 1. Section 31A-22-614.5 is amended to read:
28	31A-22-614.5. Uniform claims processing Electronic exchange of health
29	information.
30	(1) [Beginning July 1, 1993, all] All insurers offering health insurance shall:
21	(a) use a uniform claim form and uniform hilling and claim acdes, and

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32	(b) provide for the electronic exchange of uniform insurance eligibility and coverage
33	information and coordination of benefits information.
34	(2) (a) The uniform [claim forms and billing codes] electronic standards and
35	information required in Subsection (1) shall be adopted and approved by the commissioner in
36	accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. [The]
37	(b) When adopting rules under this section the commissioner:
38	(i) shall consult with [the director of the Division of Health Care Financing, the
39	National Uniform Claim Form Task Force, and the National Uniform Billing Committee when
40	adopting the uniform claims and billing codes.] national and state organizations involved with
41	the electronic exchange of health data to develop the standards for the use and electronic
42	exchange of uniform claim forms, billing and claim codes, insurance eligibility and coverage
43	information, and coordination of benefits information;
44	(ii) may not require an insurer or administrator to use a specific software product or
45	vendor; and
46	(iii) may require an insurer who participates in the All Payer Database created under
47	Section 26-33a-106.1 to allow data regarding demographic and insurance coverage information
48	to be electronically shared with the state's designated secure Health Information Master Person
49	Index to be used:
50	(A) in compliance with data security standards established by:
51	(I) federal Health Insurance Portability and Accountability Act of 1996, Pub. L.
52	104-191, 110 Stat. 1936 standards; and
53	(II) the electronic commerce agreements established in a business associate agreement;
54	<u>and</u>
55	(B) for the purpose of coordination of accident and health insurance benefits.
56	(3) (a) (i) [Beginning July 1, 1995, all insurers shall offer compatible systems of] In
57	order to facilitate the provision of Subsection (1), an insurer shall use the electronic standards
58	for electronic billing and electronic transmission of eligibility and coverage information
59	approved by the commissioner in accordance with [Title 63G, Chapter 3, Utah Administrative
60	Rulemaking Act] Subsection (2).
61	(ii) The [systems] standards approved by the commissioner may include monitoring
62	and disseminating information concerning eligibility and coverage of individuals.

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(iii) The commissioner shall coordinate the administrative rules adopted under the
provisions of this section with the administrative rules adopted by the Department of Health for
the implementation of the standards for the electronic exchange of clinical health information
under Section 26-1-37. The department shall establish procedures for developing the rules
adopted under this section, which ensure that the Department of Health is given the opportunity
to comment on proposed rules.
(b) (i) The commissioner may provide information to health care providers regarding
resources available to a health care provider to verify whether a health care provider's practice
management software system meets the uniform electronic standards for data exchange
required by this section.
(ii) The commissioner may provide the information described in Subsection (3)(b)(i)
by partnering with:
(A) a not for profit, broad based coalition of state health care insurers and health care
providers who are involved in the electronic exchange of the data required by this section; or
(B) some other person that the commissioner determines is appropriate to provide the
information described in Subsection (3)(b)(i).
[(b)] (c) The commissioner shall regulate any fees charged by insurers to the providers
for:
(i) uniform claim forms;
(ii) electronic billing; or
(iii) the electronic exchange of clinical health information permitted by Section
26-1-37.
Section 2. Effective date.
This bill takes effect on July 1, 2010.